

**U.S. Department of Labor**

Office of Administrative Law Judges  
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**Issue Date: 02 October 2006**

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In the Matter of  
J. W. A.<sup>1</sup>  
Claimant

Case No.: 2005 BLA 5283

v.

CONSOLIDATION COAL CO.  
Employer

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS  
Party in Interest

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Appearances: Mr. Joseph E. Wolfe, Attorney  
For the Claimant

Ms. Kathy L. Snyder, Attorney  
For the Employer

Before: Richard T. Stansell-Gamm  
Administrative Law Judge

**DECISION AND ORDER –  
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. J. W. A. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

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<sup>1</sup>Despite 20 C.F.R. § 725.477(b) (“A decision and order shall contain . . . the names of the parties. . .”), and over my specific objection, Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

## **Procedural Background**

This claim is Mr. A.'s first application for federal black lung disability benefits, filed on November 25, 2002 (DX 2).<sup>2</sup> On January 8, 2004, the District Director determined that Mr. A. was entitled to black lung disability benefits and designated Consolidation Coal Co. ("Employer") as the responsible operator (DX 25). On January 13, 2004, through counsel, the Employer appealed the award of benefits and requested a formal hearing before the Office of Administrative Law Judges (DX 27). The District Director awarded interim benefits to be paid from the Black Lung Disability Trust Fund on September 7, 2004 (DX 32) and forwarded the case to the Office of Administrative Law Judges on November 22, 2004 (DX 36).

After one continuance, and pursuant to a Notice of Hearing dated April 14, 2005 (ALJ I), I conducted a hearing in Abingdon, Virginia on July 27, 2005, attended by Mr. A., Mr. Wolfe, and Ms. Snyder. My decision in this case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 38, EX 1, EX 2, EX 4, and EX 5.

## **ISSUE**

Whether Mr. A. is entitled to black lung disability benefits.

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **Stipulations of Fact**

At the hearing, the parties stipulated to the following facts: a) Mr. A. had post-1969 coal mine employment; b) the length of his coal mine employment was at least 21 years; and, c) Mrs. B. A. is a dependent for the purpose of augmenting any benefits that may be payable under the Act (TR, pages 7 and 8).

### **Preliminary Findings**

Born on October 26, 1937, Mr. A. married Mrs. B. A. on February 5, 1955. Mr. A. started mining coal for Consolidation Coal Co. in 1972, and he worked in mines owned by that company for all of his career. The mines were located on the border between Virginia and West Virginia; the miners entered on the Virginia side and the coal exited on the West Virginia side. Mr. A. worked in the face, as a helper from 1972 to 1974, ran a continuous miner from 1974 to 1979, and then operated a battery scoop from 1979 to 1994. Working at a depth of at least 550 feet, Mr. A. hauled supplies and heavy timbers on the scoop. Mr. A. stopped working when the mine closed in March 1994. Mr. A. was never a smoker. (DX 2, DX 9, TR p.15-18, 20-22)

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<sup>2</sup>The following notations appear in this decision to identify exhibits: DX – Director exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

## Issue # 1 – Entitlement to Benefits

To establish entitlement to black lung disability benefits under Act, Mr. A. must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

### Pneumoconiosis

“Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment.<sup>3</sup> The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as “any chronic lung disease . . . arising out of coal mine employment.”<sup>4</sup> The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”<sup>5</sup> As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1)), autopsy or biopsy report (§ 718.202(a)(2)), regulatory presumption (§ 718.202(a)(3)),<sup>6</sup> and medical opinion (§ 718.202(a)(4)). Because the record does not contain any evidence that the claimant has complicated pneumoconiosis and Mr. A. filed this claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, Mr. A. will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

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<sup>3</sup>20 C.F.R. § 718.201(a).

<sup>4</sup>20 C.F.R. §§ 718.201(a)(1) and (2) (emphasis added).

<sup>5</sup>20 C.F.R. § 718.201(b).

<sup>6</sup>If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a coal miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the coal miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the coal miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

## Chest X-Ray Interpretations

| Date of x-ray | Exhibit | Physician                    | Interpretation  |
|---------------|---------|------------------------------|---|
| Dec. 27, 2002 | DX 10   | Dr. Forehand, B <sup>7</sup> | Positive for pneumoconiosis, profusion category 1/0, <sup>8</sup> type s/t opacities. <sup>9</sup>  |
| (same)        | DX 20   | Dr. Alexander, B, BCR        | Positive for pneumoconiosis, profusion category 1/1, type p/p opacities. Some “s” opacities in lower zones, borderline heart enlargement. |
| (same)        | DX 24   | Dr. Wiot, B, BCR             | Negative for pneumoconiosis. Atherosclerotic aorta.   |
| Nov. 5, 2003  | EX 1    | Dr. Castle, B                | Negative for pneumoconiosis. A few calcified nodes and atherosclerosis of the aorta.  |
| Aug. 4, 2004  | EX 2    | Dr. Hippensteel, B           | Negative for pneumoconiosis.  |

There are three interpretations of the December 27, 2002 chest x-ray. Dr. Forehand, a B reader, found sufficient profusion and opacities to categorize the x-ray as positive for pneumoconiosis. Dr. Alexander, a dual qualified radiologist, also found pneumoconiosis. Dr. Wiot, also a dual qualified radiologist, disagreed and found no evidence of pneumoconiosis. Based on their demonstrated expertise as dual qualified radiologists, the assessments of Dr. Alexander and Dr. Wiot have greater probative value than Dr. Forehand’s opinion.<sup>10</sup> Because the two better qualified radiologists, Dr. Alexander and Dr. Wiot, disagree on whether the chest

<sup>7</sup>The following designations apply: B – B reader and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

<sup>8</sup>The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor’s final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn’t see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102(b) (2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

<sup>9</sup>There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

<sup>10</sup> See *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist than to those of a physician who is only a B reader).

x-ray contains sufficient profusion to be positive for pneumoconiosis, I find the December 27, 2002 film to be inconclusive for the presence of pneumoconiosis.

Based on Dr. Castle's sole and uncontested interpretation, I find the November 5, 2003 x-ray is negative for pneumoconiosis.

Similarly, based on Dr. Hippensteel's sole and uncontested interpretation, I find the August 4, 2004 x-ray is negative for pneumoconiosis.

In summary, setting aside the inconclusive study from December 27, 2002, the remaining two chest x-rays in the record (November 5, 2003 and August 4, 2004) are negative for pneumoconiosis. Consequently, the preponderance of the chest x-ray evidence is negative and Mr. A. is unable to establish the presence of pneumoconiosis in his lungs through radiographic evidence under 20 C.F.R. § 718.202(a)(1).

### Medical Opinion

Although Mr. A. cannot establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202(a)(4) through the preponderance of the more probative medical opinion. Prior to considering the various medical assessments of Mr. A.'s pulmonary condition, a review of the other medical evidence in the record helps to understand the medical opinions.

### Pulmonary Function Tests

| <b>Exhibit</b> | <b>Date / Doctor</b>            | <b>Age / Height</b> | <b>FEV<sub>1</sub> pre<sup>11</sup> post<sup>12</sup></b> | <b>FVC pre post</b> | <b>MVV pre post</b> | <b>% FEV<sub>1</sub> / FVC pre post</b> | <b>Qualified<sup>13</sup> pre post</b> |
|----------------|---------------------------------|---------------------|---|---------------------|---------------------|---|--|
| DX 10          | Dec. 27, 2002<br>Dr. Forehand   | 65<br>67"           | 3.04  | 3.60                | 97                  | 84%                                     | No <sup>14</sup>                       |
| EX 1           | Nov. 5, 2003<br>Dr. Castle      | 66<br>67"           | 2.58<br>2.56  | 3.11<br>3.01        | 74                  | 83%<br>85%                              | No <sup>15</sup>                       |
| EX 2           | Aug. 4, 2004<br>Dr. Hippensteel | 66<br>67"           | 2.18<br>1.94  | 2.83<br>2.30        | 48                  | 77%<br>84%                              | No                                     |

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<sup>11</sup>Test result before administration of a bronchodilator.

<sup>12</sup>Test result after administration of a bronchodilator.

<sup>13</sup>Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV<sub>1</sub> must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), and either the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal or less than the value in Table B5, or the ratio FEV<sub>1</sub>/FVC has to be equal to or less than 55%.

<sup>14</sup>Qualifying FEV<sub>1</sub> value is 1.73 or less.

<sup>15</sup>Qualifying FEV<sub>1</sub> value is 1.71 or less.

## Arterial Blood Gas Studies

| Exhibit | Date / Doctor                   | pCO <sub>2</sub> (rest)<br>pCO <sub>2</sub> (exercise) | pO <sub>2</sub> (rest)<br>pO <sub>2</sub> (exercise) | Qualified                             |
|---------|---------------------------------|--|--|---------------------------------------|
| DX 10   | Dec. 27, 2002<br>Dr. Forehand   | 39<br>35   | 68<br>63   | No <sup>16</sup><br>Yes <sup>17</sup> |
| EX 1    | Nov. 5, 2003<br>Dr. Castle      | 40.5<br>35.3   | 70.9<br>68.1   | No <sup>18</sup><br>No <sup>19</sup>  |
| EX 2    | Aug. 4, 2004<br>Dr. Hippensteel | 39.4<br>30.8   | 71.4<br>75.4   | No<br>No <sup>20</sup>                |

### Dr. J. Randolph Forehand (DX 10)

On December 27, 2002, Dr. Forehand, board certified in pediatrics and allergy/immunology, examined Mr. A.'s pulmonary health. Mr. A. had 21 years of underground coal mine employment and never smoked. Mr. A.'s medical history included wheezing since February 2000, arthritis, and high blood pressure since 1980. Mr. A. complained of daily sputum, 20 years of dyspnea, and coughing. At the time of examination, Mr. A. was 5' 7" tall and weighed 209 pounds; his blood pressure was 230/90. Dr. Forehand heard crackles at both bases. The chest x-ray was positive for pneumoconiosis. The pulmonary function test showed a "normal ventilatory pattern." The arterial blood gas study showed hypoxemia with exercise and no metabolic disturbance. The electrocardiogram ("EKG") contained no acute changes (although the computer strip indicated the study was abnormal). Based on the positive chest x-ray, employment history, physical examination and arterial blood gas study, Dr. Forehand diagnosed pneumoconiosis due to coal dust exposure. Dr. Forehand found "insufficient residual oxygen transfer capacity remains to continue in last coal mining job. Unable to work. Totally and permanently disabled." According to Dr. Forehand, coal workers' pneumoconiosis was the "sole" factor contributing to Mr. A.'s totally disabling respiratory impairment.

### Dr. James R. Castle (EX 1, EX 5)

On November 5, 2003, Dr. Castle, board certified in internal medicine and pulmonary disease, evaluated Mr. A.'s pulmonary health. Mr. A. worked in the mines from 1972 to 1994 and was a lifelong nonsmoker. He had a history of mild hypertension and he complained of shortness of breath. Mr. A. was 5' 7" tall and weighed 200 pounds. His blood pressure was 160/60. Upon physical examination, Dr. Castle noted normal and equal breath sounds. The

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<sup>16</sup>For a pCO<sub>2</sub> of 39, the qualifying pO<sub>2</sub> is 61 or less.

<sup>17</sup>For a pCO<sub>2</sub> of 35, the qualifying pO<sub>2</sub> is 65 or less.

<sup>18</sup>For a pCO<sub>2</sub> of 40-49, the qualifying pO<sub>2</sub> is 60 or less.

<sup>19</sup>For a pCO<sub>2</sub> of 36, the qualifying pO<sub>2</sub> is 64 or less.

<sup>20</sup>For a pCO<sub>2</sub> of 31, the qualifying pO<sub>2</sub> is 69 or less.

chest x-ray was negative for coal workers' pneumoconiosis but there were a few calcified nodes and atherosclerosis of the aorta. The pulmonary function test showed "only a minimal decline in the forced vital capacity without large airway obstruction or restriction." The arterial blood gas study produced normal resting and exercise levels. The EKG was abnormal. Based on his examination, Dr. Castle concluded Mr. A. did not have coal workers' pneumoconiosis and was not totally disabled. His sole diagnosis was an abnormal EKG which he gave to Mr. A. for referral to his physician.

Dr. Castle also examined the additional medical information about Mr. A. including medical records from Bluefield Regional Medical Center,<sup>21</sup> Dr. Forehand's exam dated December 27, 2002, and Dr. Wiot's radiographic report of the December 27, 2002 chest x-ray. Based on his own examination and review of other submitted medical data, Dr. Castle again concluded that there was no evidence of coal workers' pneumoconiosis in the chest x-rays, physical exam, or physiologic testing. He also found no respiratory impairment. Dr. Castle noted that Mr. A. worked in the mines long enough to have developed pneumoconiosis if he was a susceptible host. However, Dr. Castle pointed to another risk factor for the development of pulmonary disease: cardiac disease. Dr. Castle characterized Mr. A.'s EKG as irregular and consistent with ischemia, an indicator of coronary artery disease. He also noted the absence of "any consistent" findings indicating the presence of an interstitial disease. In particular, although Dr. Forehand found a decline in blood oxygenation upon exercise, Dr. Castle's exercise test did not produce a similar result. As a result, Dr. Castle believed the decline in Dr. Forehand's test may have been due to cardiac disease because the associated EKG showed evidence consistent with myocardial ischemia.

In a deposition on July 15, 2005, Dr. Castle observed that at the time of his examination, Mr. A. was taking medication for hypertension. The exam EKG indicated Mr. A. may have an old anterior myocardial infarction. When Mr. A. was examined by Dr. Forehand, his hypertension was "poorly controlled." As a result, the drop in oxygenation level upon exercise was due to his hypertension rather than a respiratory insufficiency. Whereas, when Dr. Castle conducted the evaluation, Mr. A. was not as hypertensive and he did not experience a drop in oxygenation upon exercise. In Dr. Castle's opinion, any impairment Mr. A. suffers is due to an intrinsic heart condition. Based on his review of the entire record, Dr. Castle opined Mr. A. does not have coal workers' pneumoconiosis. Additionally, Mr. A. is not totally disabled due to a pulmonary or respiratory impairment.

Dr. Kirk E. Hippensteel  
(EX 2, EX 4)

On August 4, 2004, Dr. Hippensteel, board certified in internal medicine, pulmonary disease, and critical care, examined Mr. A.'s pulmonary health. Mr. A. worked as an underground coal miner for 21 years and was never a smoker. Mr. A. complained of breathing problems, sputum, and occasional chest pain when walking uphill. Mr. A.'s history included

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<sup>21</sup>Although such treatment records would be admissible under 20 C.F.R. § 725.414, the documents were not in the record. Their absence has little significance since Dr. Castle indicated the records indicated Mr. A. had been scheduled for several tests.

hypertension for the last 10 to 15 years, for which he was medicated, and arthritis. At the time of the exam, he was 5' 7" tall and weighed 210 pounds. His blood pressure was 155/70.

Upon physical examination, Dr. Hippensteel heard no rales or wheezes with good air movement. The chest x-ray was negative for pneumoconiosis, but showed compression of basilar lung markings aggravated by obesity, with possible mild pulmonary vascular congestion and borderline cardiomegaly. Due to suboptimal effort, the pulmonary function studies underestimated Mr. A.'s pulmonary capacity. Nevertheless, the study showed no evidence of a pulmonary obstruction. The arterial blood gas study indicated normal gas exchange, both at rest and with exercise. The EKG revealed normal sinus rhythm with a long QT interval. Based on his examination, Dr. Hippensteel opined that Mr. A. did not have either coal workers' pneumoconiosis or a respiratory impairment. Dr. Hippensteel attributed Mr. A.'s reduced exercise tolerance and dyspnea to hypertension and obesity.

Dr. Hippensteel also reviewed Dr. Forehand's December 27, 2002 exam and Dr. Castle's April 4, 2004 exam. Dr. Hippensteel described Dr. Forehand's chest x-ray interpretation as not typically indicative of coal workers' pneumoconiosis because of the location and type of opacities observed by Dr. Forehand. Based on his review, Dr. Hippensteel observed that Dr. Forehand's clinical findings were not consistent with the other doctors who examined Mr. A. Specifically, the chest x-rays did not demonstrate pneumoconiosis and the blood gas studies were not consistently demonstrating a disabling impairment. Dr. Hippensteel also noted that at the time of Dr. Forehand's pulmonary evaluation, Mr. A. had severe hypertension, which can cause a reduction in cardiac output with exercise. Mr. A.'s variable hypertension and obesity can cause dyspnea and limited exercise tolerance.

In a July 15, 2005 deposition, Dr. Hippensteel noted that Mr. A.'s body mass index was "obese." Further, during Dr. Forehand's pulmonary evaluation, Mr. A.'s blood pressure was "very elevated" at 230/90, which is "markedly above normal." High blood pressure can cause decreasing cardiac performance because the increased pressure diminishes the heart's ability to properly oxygenate the blood. Notably, in the later exercise arterial blood gas studies conducted by Dr. Castle and Dr. Hippensteel, when Mr. A.'s blood pressure was improved, the test results were normal. Again, based on all the medical evidence in the record, Dr. Hippensteel concluded Mr. A. did not have coal workers' pneumoconiosis and was not totally disabled due to a pulmonary impairment.

### Discussion

Dr. Forehand diagnosed pneumoconiosis. Dr. Castle and Dr. Hippensteel did not find that Mr. A. had pneumoconiosis. Due to this conflict in medical opinion, I must first assess the relative probative value of each respective opinion in terms of documentation, reasoning, and medical qualifications.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of



medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Third, a physician who is board certified in the field of pulmonary disease and who has extensive experience in this area may be accorded greater deference because of his or her expertise. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Burns v. Director, OWCP*, 7 BLR 1-597 (1984).

With these principles in mind, I find that Dr. Forehand's opinion suffers loss of probative value due to his reliance in part on both inaccurate and incomplete documentation. Although Dr. Forehand based his diagnosis of coal workers' pneumoconiosis on all aspects of his evaluation, he relied in part on his positive interpretation of the December 27, 2002 chest x-ray. However, I have determined that chest x-ray is inconclusive for the presence of pneumoconiosis and the preponderance of the radiographic evidence is actually negative for pneumoconiosis. Additionally, since Dr. Forehand only considered the test results of his pulmonary examination, he was unaware that two subsequent pulmonary evaluations by Dr. Castle and Dr. Hippensteel produced exercise arterial blood gas studies which were normal and did not reproduce Dr. Forehand's finding of total disability. Since Dr. Forehand also relied in part on the exercise arterial blood gas study showing a disabling impairment, the additional tests call into question the viability of his use of the exercise arterial blood gas studies as a partial basis for finding that Mr. A. has pneumoconiosis.

In a well documented, reasoned, and probative medical opinion, Dr. Castle, a board certified pulmonologist, conducted a thorough assessment of all the medical evidence in the record. Based on that comprehensive analysis, and consistent with my determination, Dr. Castle found insufficient radiographic evidence to diagnose clinical pneumoconiosis. Further, relying on the significant change in Mr. A.'s blood pressure in the two later pulmonary evaluations and the corresponding normal exercise arterial blood gas studies, Dr. Castle reasonably attributed Mr. A.'s pulmonary difficulties to the variable extent of his hypertension, rather than pneumoconiosis or his exposure to coal mine dust.

Similarly, having also comprehensively considered all three pulmonary evaluations, Dr. Hippensteel, a board certified pulmonary disease physician, also provided a well documented, reasoned, and probative medical determination that Mr. A. does not have coal workers' pneumoconiosis. Integrating the objective medical evidence, Dr. Hippensteel reasonably concluded the preponderance of the radiographic evidence is negative for pneumoconiosis and

the neither the pulmonary function tests nor the preponderance of the arterial blood gas studies support a finding of legal pneumoconiosis. Citing Mr. A.'s elevated blood pressure and hypertension at the time of Dr. Forehand's exam, Dr. Hippensteel provided a sufficiently probative explanation for attributing Mr. A.' oxygenation difficulty in December 2002 to his hypertension.

Due to the diminished probative value of Dr. Forehand's evaluation and based on the probative opinions of Dr. Castle and Dr. Hippensteel, I find Mr. A. does not have either clinical or legal pneumoconiosis. Consequently, Mr. A. is unable to establish the presence of pneumoconiosis through probative medical opinion under 20 C.F.R. § 718.202(a)(4).

### **CONCLUSION**

Since the preponderance of the chest x-ray evidence is negative, Mr. A. is unable to establish the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(1). Since the more probative medical opinion demonstrates that Mr. A. did not have either clinical or legal pneumoconiosis, Mr. A. is also unable to prove the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(4). Accordingly, Mr. A. has failed to prove the first requisite element of entitlement—the presence of pneumoconiosis—and his claim for black lung disability benefits must be denied.<sup>22</sup>

### **ORDER**

The black lung disability claim of MR. J. W. A. is **DENIED**.

**SO ORDERED:**

**A**  
RICHARD T. STANSELL-GAMM  
Administrative Law Judge

Date Signed: **October 2, 2006**  
Washington, DC

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

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<sup>22</sup>Since Mr. A. failed to prove the presence of pneumoconiosis, I need not address the remaining three entitlement issues.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).